

## HOSPITAL HEALTH CARE PAYMENT MECHANISMS

### INTRODUCTION

Payment for hospital services is made by various means—public and private, direct and indirect. Each of these methods has different implications for hospitals' financial health. Public payments have become a larger proportion of hospitals' revenue at a time when state and federal governments have sought to control their health care costs by reducing reimbursements and establishing managed care programs for Medicare and Medicaid.<sup>1</sup> Medicare and Medicaid presently reimburse hospitals at only 95% and 71% respectively of their current costs.<sup>2</sup> In the past, private payments have compensated for lower public reimbursements and charity care. Private payers, who are largely employers, have also sought to contain increasing health care costs. Managed care fee schedules, capitated rates, and discount rates have established restrictions on private reimbursements and transferred more of the financial risk of care to hospitals. This has an impact on hospitals' flexibility to shift costs from public to private payers.

This discussion provides a basic overview of the variety of private payers and public payment mechanisms. Private funds consist of individuals' out-of-pocket expenditures, private health insurance, philanthropy and non-patient revenues, such as investment or rental income. Public health care expenditures include federal, state and local government programs, most notably Medicare and Medicaid. This discussion will include the evolution of payment trends, the impact of recent federal legislation on hospital payments, and how cost shift changes have influenced hospital finances. It also will include the recommendations from a

focus group on payment mechanisms that involved participants from hospitals, commercial payers, the state medical society, bond insurers, hospital auditors and public health insurers.

### DIRECT PRIVATE FINANCING MECHANISMS

#### **Uncompensated Care; Charity Care/Bad Debt**

Hospitals originally were charitable organizations that provided free medical care for indigents, veterans, and those who were chronically ill. Doctors donated their services and the cost of care was underwritten through philanthropy and government stipends. Despite the transformation of the role of hospitals in the health care delivery system, Connecticut acute care hospitals are still required to provide emergency care to all those who need it, including those who cannot pay for it.<sup>3</sup>

Uncompensated care includes both charity care (services provided to patients at no charge and where no payment is expected) and bad debt (payment for services provided was anticipated but not received). The amount of uncompensated care provided by a hospital is dependent upon a variety of factors including community demographics, the availability and level of health care programs offered to the uninsured within the community, and the enforcement of hospital collection practices. In Connecticut for Fiscal Year (FY) 1999, uncompensated care represented 6.25% of hospital expenses, slightly above the national average of 6%.<sup>4</sup>

Uncompensated care in the United States is concentrated within urban public hospitals and teaching hospitals whose major funding comes from public sources. Nationally, urban public hospitals account for one-third of all uncompensated care in this country—double their share

of the total hospital market. Unlike most other states, uninsured people are not channeled into specific hospitals that are designated and funded to care for the poor. All of the state's hospitals service uninsured and underinsured patients. In Connecticut, the state's five large urban hospitals accounted for 21% of uncompensated care in 1999.<sup>5</sup>

Across the country, much of the uncompensated care in public hospitals is concentrated within the teaching hospital segment. Major public teaching hospitals typically provide triple the amount of uncompensated care relative to their share of the overall hospital market. Hospitals in the most competitive markets tend to be in large cities, are bigger in size, have a larger Medicaid mix, and account for more of the public and major teaching hospitals (characteristics associated with higher levels of uncompensated care).

### **Self-Pay**

As advances in medical technology during the earlier decades of the 20th century made hospitals more central to the delivery of health care, the percentage of self-paying patients increased. An examination of the annual reports of Connecticut hospitals shows that from the 1920s to the 1960s, this percentage grew from around one-fifth to just under one-half of all patients. Since that time, the percentage of self-payers has declined so that by FY 1999 only 2.2% of all acute care hospital inpatients were self-payers.<sup>6</sup> Hospitals bill these "self-pay" patients at the

published rate for services, unless the individual has negotiated a different, discounted rate or method of payment with a hospital. Generally, discounts granted to a self-pay individual by the hospital range from 3% to 10%, as opposed to the 20% to 30% discounts arranged with managed care payers.<sup>7</sup>

### **Fee-for-Service/Indemnity Insurance**

While medical advances transformed the role of hospitals in the delivery of health care, the development of indemnity insurance greatly expanded the number of people who had access to acute care. The result was a heightened demand for acute care services and establishment of hospitals as the central element in the health care delivery system. The birth of modern health insurance as a means for paying for hospital services occurred in 1929 when a group of schoolteachers contracted with Baylor Hospital in Dallas, Texas to provide room, board and certain ancillary services at a predetermined monthly cost.<sup>8</sup> This plan guaranteed these teachers 21 days of hospital care for \$6.00 a year. It was the forerunner of what is

known today as Blue Cross. Blue Cross was attractive not only to consumers but also to hospitals because payments were made directly from the plan to hospitals, rather than reimbursing the patients who would then pay the hospitals.<sup>9</sup>

During World War II, wages were frozen to prevent inflation and so employers offered group health insurance in order to attract and retain workers.<sup>10</sup> Health



insurance soon became an employee benefit when the Supreme Court ruled that health insurance benefits were a legitimate part of the labor- management bargaining process.<sup>11</sup> By the mid-1950s, health insurance had expanded rapidly, as 77 million Americans had hospital expense insurance in either the indemnity form or under a major medical plan. These same types of health insurance plans, although expanded, are still in wide use today. By 1997, there were 151.7 million people covered by employer-provided plans.<sup>12</sup>

Up until the 1970s, the majority of privately insured individuals had traditional indemnity health insurance coverage, also known as fee-for-service.<sup>13</sup> Under fee-for-service, the insurance company or other payer reimburses providers on the basis of a fee schedule that either approximates the costs of services or is a percent-age discount off the actual charges.<sup>14</sup>

**Managed Care’s Transformation of Commercial Insurance**

Health care costs rose dramatically in the 1970s and 1980s.<sup>15</sup> During the late 1980s and early 1990s, the proportion of employers offering health care coverage declined, most likely due to double-digit growth rates in the cost of employer-sponsored health insurance during this time. Faced with premium increases, many employers have in recent years shifted from conventional indemnity/fee-for-service plans to less expensive managed care plans. The move to managed care was an attempt by concerned employers to control escalating health care expenses. These managed care health delivery systems offered the potential for controlling costs by organizing health care providers into networks and by integrating the financing and delivery of medical care.<sup>16</sup>

In the spring of 1994, the Connecticut General Assembly responded to rising costs by creating a more competitive health care market. It deregulated hospital prices and allowed all health care payers to negotiate different rates and payment methods with hospi-tals. Managed care dis-count agreements were intended to guarantee hospitals patient vol-ume while providing discounts on standard hospital charges to managed care organi-zations. Although each of Connecticut’s acute care hospitals has negotiated and entered into alternate payment arrangements with payers, the types of agreements and negotiated rates vary significantly depending upon hospital service, volume levels and location.<sup>17</sup> In the first two years following deregulation, the number of managed care agreements mushroomed by 244% from 163 to 560 agreements. From FY 1994 to FY 1998, the statewide average discount rate grew from 9% to 31% of total hospital charges.<sup>18</sup>

HMOs rapidly expanded in Connecticut’s newly competitive health care market. From the early 1990s until 2000, HMO enrollment of Connecticut citizens increased from 24% to 43%, or from approximately 800,000 to 1.4 million persons.<sup>19</sup>

Managed care is itself a broad term that encompasses many payment and review mechanisms, collaborations and types of organizations including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point-of-Service organizations (POS), Exclusive Provider Organizations (EPOs), Physician Hospital Organizations (PHOs)

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and Integrated Delivery Systems (IDS), among others. These organizations employ or contract with a provider network that delivers services to enrollees and either shares risk with the plan or has some incentives to provide cost-effective quality care. They offer policyholders significant financial incentives to use the providers within a network and usually

contain explicit standards for selecting providers and a formal procedure to assure quality care.<sup>20</sup> Through gatekeepers, utilization reviews, and practice protocols, managed care organizations seek to influence the delivery of health care services, which impacts hospital revenues. They

also affect this by their payment mechanisms, discounted fee schedules and capitated rates, which restrict the growth of charges and shift more of the risk of care to providers such as hospitals. Charges that exceed pre-published fee schedules or the capitated rate must be billed to patients or absorbed by the provider.

Today, managed care is at a crossroads. Demand is rising for more services and greater choice of providers and treatments. POS and PPO plans are now the dominant forms of managed care delivery. Consumers are expressing their frustrations and concerns with the existing managed care system. Connecticut Public Act 99-284 established an Office of Managed Care Ombudsman to assist consumers with, among other things, filing complaints and appeals with managed care organizations. Hospitals, physicians and other health care providers are voicing their dissatisfaction with the system as well. Furthermore, advances in medical technology and pharmaceuticals are leading

to more costly care. Many experts believe all the cost savings available under gatekeeper structures, pre-authorization requirements, and utilization management have already been achieved.<sup>21</sup>

## DIRECT PUBLIC FINANCING MECHANISMS

Historically, state and local governments have provided funding to hospitals for the care of indigents and the chronically ill. These programs did not provide systematic coverage and the type of services they provided varied greatly by locality. Following the Civil War, the federal government granted stipends to hospitals for the care of veterans. While government funding has always been an important source of revenue for acute care hospitals, 19th century hospital administrators lamented that these grants were insufficient to cover the cost of care; the same complaints are voiced today by their 21st century counterparts.<sup>22</sup>

The federal government became a significant payer of health care expenses beginning in the 1960s. During the presidential campaign of 1960, the mass media re-discovered poverty in America. As part of his "Great Society" program, President Lyndon Johnson committed the federal government to funding health care for senior citizens and the poor. He believed these initiatives to be the first steps toward a national health care system. In 1965, Congress passed legislation establishing the Medicare and Medicaid programs as Title XVIII and Title XIX of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly and in 1973, added the severely disabled and certain persons with kidney disease. Medicaid was created to fund health care for low-income households and the disabled. Medicare and Medicaid have

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made government the United States' largest single payer of health care costs, at \$507 billion in FY 1997.<sup>23</sup> In hospital FY 1999, Connecticut Medicare payments accounted for about 45% of total payments to hospitals, and Connecticut Medicaid payments represented roughly 10%.<sup>24</sup> During the 1990s, hospitals became increasingly reliant upon government reimbursements as the proportion of revenue from government increased. At the same time, federal and state governments ratified measures to slow the growth of and even reduce their health care costs.

### Medicare

As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors and disability insurance benefits under Title II of the Social Security Act. Medicare is the largest federal health care program. When first implemented in 1966, it had 19.1 million enrollees; by 1998 its coverage had extended to 39 million Americans, many of whom are disabled.<sup>25</sup> This number represents 14.4% of the total U.S. population and 86% of all senior citizens. In FY 1998, total Medicare gross revenue was \$3 billion for Connecticut's acute care hospitals, which is just less than half of the total statewide hospital gross revenue.<sup>26</sup>

Medicare consists of two primary components that are separate but coordinated fee-for-service programs.<sup>27</sup> Hospital Insurance (HI), also known as Part A, pays for inpatient hospital care, skilled nursing facility, home health, and hospice care. Covered inpatient hospital care includes all services ordinarily furnished by a hospital to its patients, such as semiprivate accommodations, meals, operating and recovery rooms, laboratory procedures

and X-rays, drugs, nursing services, therapy services and services of interns and residents-in-training. The second part of Medicare is known as Supplementary Medical Insurance (SMI), or Part B. Part B helps pay for physician, outpatient, home health care, and various other medical services. SMI coverage is optional and requires payment of a monthly premium.

### *Impact of Medicare's Prospective Payment System Upon Hospitals*

For Medicare beneficiaries, reimbursement for physicians and hospitals was on a retrospective, fee-for-service basis until 1983. At that time, the federal government, seeking to control health care costs, introduced the Prospective Payment System (PPS) for hospital inpatient services based on diagnosis related groups (DRGs), or broad groupings of diseases and procedures drawn from the International Classifications of Disease. Prior to the implementation of the PPS, hospitals submitted patient charges to Medicare and recovered their expenses within Medicare's principles of reimbursement, regardless of whether these expenses were high or low, excessive or prudent. There were few incentives for cost efficiency under this system.<sup>28</sup> Under the Prospective Payment System, hospitals are reimbursed a fixed, predetermined amount that is based upon a patient's diagnosis within a DRG. Reimbursements are adjusted to account for local wages, urban versus rural location, and whether or not the hospital is a teaching hospital.<sup>29</sup> The PPS created economic incentives for hospitals to

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conserve resources, as they would have to absorb the cost of care when it exceeded the fixed reimbursement level.

Along with payer preferences and technological changes, the DRG system contributed to a shift of Medicare patients from inpatient to outpatient settings where services could be charged on a fee-for-service basis. PPS has had a significant effect on Medicare expenditures; Medicare expenditures for inpatient care are approximately 20% lower than they would have been without the implementation of PPS.<sup>30</sup>

In 1998, the Health Care Financing Administration proposed a prospective payment system for hospital outpatient services that will replace the current cost-based system with one using ambulatory payment classifications (APCs). Once implemented, this new



outpatient PPS will use 346 APC groups to pay hospitals for outpatient services delivered to Medicare beneficiaries. Under this system, hospitals will receive proportionately less for services that are currently paid based on costs and more for services that had been paid under blended payment methods. It is expected

that, similar to the experience with the inpatient PPS, the outpatient PPS will affect the behavior of hospitals, including the types and volumes of certain procedures that hospitals perform. Hospitals will have an incentive to perform a lower-cost procedure within a given APC versus a higher-cost procedure within the same APC, since the payment rate for both procedures will be the same.<sup>31</sup>

#### *Medicare Managed Care*

Beginning in FY 1996, Medicare Managed Care began to operate as approved HMOs offered coverage to Medicare enrollees. In Connecticut for FY 1998, hospitals received \$354 million from Medicare Managed Care; this represents 11% of total gross Medicare revenues.

The Balanced Budget Act (BBA) of 1997 established a third part of Medicare, known as Part C or Medicare+Choice, which began to provide services to enrollees on January 1, 1998. The establishment of Medicare+Choice was intended to expand the array of insurance plan choices beyond fee-for-service indemnity coverage and HMOs to include Preferred Provider Organizations and Provider Sponsored Organizations. The reform was also an effort to strengthen Medicare's finances by including policies further constraining payments to providers in the traditional fee-for-service program and in managed care plans.<sup>33</sup> Unfortunately, the program has not been without problems. Forty-three of the 347 HMO plans in which Medicare+Choice beneficiaries were enrolled announced plans to not renew their contracts with Medicare in 1999, citing financial losses and other problems. An additional 54 HMOs announced their intention to reduce the number of geographic areas in which they would enroll beneficiaries. These plans cited HCFA's reduced payment rates (per the BBA) as



too low and the law's new regulations as too burdensome.<sup>34</sup>

Most Medicare beneficiaries are still covered under the program's traditional components of prospective payment for inpatient care combined with fee-for-service payments to physicians. The program's original structure remains the same, with the exception of the imposition of administered prices through the prospective payment system for hospitals and the Medicare fee schedule for physicians' services. Under Medicare's traditional insurance program, all physicians and hospitals that meet Medicare's conditions of participation take part in the program regardless of whether they are affiliated with health plans or aggregated in medical groups.<sup>35</sup>

*The Balanced Budget Act of 1997 and Balanced Budget Refinement Act of 1999*  
The Medicare provisions of the Balanced Budget Act of 1997 (BBA), Public Law 105-33, reduced payments for most hospital-based services, e.g., inpatient and outpatient care, home health care, skilled nursing care, medical education, indigent care, and many other services. This Act is projected to reduce Medicare payments to Connecticut hospitals by \$1.1 billion over five years.<sup>36</sup> The Medicare Balanced Budget Refinement Act of 1999 (BBRA), effective in FY 2000, will restore some portion of the Medicare funding that was cut in the BBA, however the industry has noted that BBRA payment increases have only partially reduced (by about 1%) the severity of BBA-mandated hospital payment reductions. Drawing conclusions about the BBAs impact on the overall financial status of hospitals is somewhat difficult, as it depends on a wide variety of factors including other Medicare payment policies, Medicaid payment changes, the growth of uncompensated

care and private insurance trends—all of which are evolving rapidly.

### **Medicaid**

Medicaid, Title XIX of the Social Security Act, is a federal-state matching entitlement program that pays for medical assistance for certain economically and medically needy individuals and families with low incomes and resources. It is the largest source of funding for medical and health-related services for America's poorest people. In 1996, it provided health care assistance to more than 36 million persons, at a cost of \$160 billion dollars.<sup>37</sup>

Within federal guidelines, states set their own Medicaid standards of eligibility; determine the type, amount, duration and scope of covered services; and administer their programs. Medicaid policies for eligibility, services, and payment are complex, and vary considerably even among similar sized and/or adjacent states, meaning that a person who is eligible for Medicaid in one state might not be eligible in another state. Also, services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. Medicaid eligibility and/or services within a state can change during the year.

States may pay providers directly, or pay for Medicaid through various prepayment arrangements, such as HMOs. Each state generally has broad discretion in determining the payment methodology and rate for services. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. In FY 1998, Medicaid payments to Connecticut hospitals represented approximately 10% of total gross revenue, or \$792 million.<sup>38</sup> However, Connecticut has the nation's third lowest Medicaid reimbursement rate relative to the cost of care, at 71% of costs.

The State of Connecticut itself pays 50% of the total costs for its Medicaid program, which is the largest share that any state is required to contribute.<sup>39</sup>

Most states have an uncompensated care program that makes additional payments to qualified hospitals that provide services to a disproportionate number of Medicaid

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recipients and/or to other low-income or uninsured persons under what is known as “disproportionate share hospital” (DSH) payments. With the passage of the BBA in 1997, state allotments for payments to DSH hospitals

have become increasingly limited. In addition, the BBA’s repeal of the Boren Amendment weakened hospitals’ bargaining power with the Medicaid program.<sup>40</sup>

Title XXI of the Social Security Act, known as the State Children’s Health Insurance Program (SCHIP), is a relatively new program initiated by the BBA. Title XXI allowed states to craft or expand an existing State insurance program in order to extend Medicaid eligibility to include more uninsured children.<sup>41</sup> Connecticut’s SCHIP program, Healthcare for UninSured Kids and Youth (HUSKY), uses a combination approach with a non-Medicaid option for uninsured residents under age 19 and above 185% of the federal poverty level.

### Medicaid Managed Care

A significant development in Medicaid is the growth of managed care as an alternative service delivery method different from the traditional fee-for-service system. Since the 1980s, many states have experimented with managed care as a means of limiting Medicaid expenditures. Sections

1915(b) and 1115 of the Social Security Act allow states to apply for waivers that provide them with greater flexibility in the design and implementation of their Medicaid managed care programs. Section 1915(b) of the law allows states to develop innovative health delivery or reimbursement systems. Section 1115 of the law allows statewide health care reform demonstrations for testing various methods of covering uninsured populations, and testing new delivery systems without increasing costs. Under Medicaid managed care, HMOs, prepaid health plans or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic prepayment per enrollee.

The BBA of 1997 eliminated the waiver requirement altogether, except for persons who are eligible for both Medicare and Medicaid (disabled and elderly poor people), children with special needs and Native Americans. Currently, all states except Alaska now rely on some form of managed care to serve their Medicaid population.<sup>42</sup> Connecticut introduced Medicaid managed care in FY 1995 and as of June 30, 1999, 71% of Connecticut’s 322,181 Medicaid enrollees were in managed care.<sup>43</sup> In FY 1998, hospital revenues from Medicaid managed care totaled \$312 million, or 40% of total Medicaid revenues.<sup>44</sup>

### INDIRECT PAYMENT MECHANISMS

#### Other Operating Revenue, Non-Operating Income from Philanthropic and Non-Philanthropic Sources

In addition to direct funding of health care services by public and private payers, hospitals have several sources of other/non-operating revenue. Other operating revenue includes income not directly related to patient care, patient services, or the sale of patient care goods, and



includes purchase discounts, television commissions, and leased land rental revenue. Non-operating income, which can be classified as either philanthropic or non-philanthropic, includes unrestricted gifts, unrestricted income from endowment funds, income gains from investments of restricted funds, gains on the sale of hospital properties, and net rentals of facilities not used in the operation of the hospital, such as parking garages and cafeterias. Nationally, about half of hospital budget surpluses come from non-operating income. In Connecticut during FY 1999, hospitals earned \$81.6 million from total hospital non-operating, non-philanthropic sources.

**Philanthropic Funds**

Philanthropic and corporate foundations or giving programs indirectly finance health care by issuing money, usually in the form of grants, to research methods of improving health and/or health care. Health philanthropies generally aim for the greatest number of beneficiaries. In addition to donations from foundations, hospitals may receive gifts of money, stock, bonds or other property from donors for the purpose of establishing a fund to provide medical care to patients. These funds may be established by gift, bequest, subscription or dedication. They may be either restricted or non-restricted, that is, there may be donor stipulations that limit the use or recipients of donated funds. For example, Connecticut hospitals have received donations stipulating funds may be used only to provide hospital care for patients with a specific disease, from a particular town, or in a particular

age group. Hospitals may also solicit donations for the specific purpose of establishing funds to provide medical care.

Hospitals may have their own foundations dedicated to providing financial resources on an ongoing basis. These foundations raise funds through annual appeals, planned giving, endowment funds and capital campaigns. Often, a separate volunteer board of directors manages such foundations, and is responsible for its management to ensure that there is adequate financial support to assist in meeting the hospital's immediate and long-term objectives. In FY 1999, 24 of Connecticut's

31 acute care hospitals reported non-operating, philanthropic revenue, ranging from \$11,983 to \$22,528,993. With declining commercial and public reimbursements, hospitals are becoming increasingly reliant on philanthropic funds to maintain their financial equilibrium.

**Investment Income**

Hospitals may also indirectly finance health care through investment income, where trusts, endowments and cash are invested in vehicles such as securities or real estate, which may ultimately generate hospital income.

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## CONCLUSION

Hospital spending continues to consume the largest portion of the health care dollar and is financed by a variety of revenue sources including private and commercial payers, public programs, investment and non-operating revenue, and philanthropy. In the past several

decades, the health care system has seen dramatic changes in the way health care, hospital care in particular, is delivered and funded. The mix of services offered by most hospitals has shifted from inpatient stays toward greater use of outpatient and post-discharge services such as home health care and skilled nursing facilities.

On the financial side, hospitals are

experiencing tightening commercial and public reimbursements. As a result, the statewide annual growth of hospital revenues has stagnated at 1%. Commercial payers have moved from traditional fee-for-service toward managed care that imposed tighter restrictions on the utilization of services and reimbursement for care. Following the 1994 deregulation of Connecticut's health care market, the number of managed care enrollees has grown to 1.4 million, or 43% of the state's total population. Acute care hospitals have become increasingly dependent

upon government reimbursement—nearly 60% of their total revenue in FY 1999—at a time when state and federal governments have needed to rein in health care costs by adopting managed care for the Medicare and Medicaid programs. In Connecticut, 71% of all Medicaid enrollees are in managed care and, although Medicare managed care has developed more slowly, it still accounted for \$354 million in hospital reimbursements in FY 1998. Hospital dependence upon government revenues weakens their financial stability because Medicare and Medicaid reimbursements currently cover 95% and 71% respectively of their costs of care.

If patient care payment-to-cost ratios decline consistent with current Medicare policy, state budget recommendations and market expectations, then hospital operating losses are likely to increase, placing additional pressure on private payers to offset public payer shortfalls. In the past, hospitals relied upon private payers to cover the payment shortfalls of Medicare, Medicaid, and uncompensated care. Given the increased competitive pressures in the private insurance marketplace, commercial payers are unwilling to increase their reimbursements to hospitals to cover Medicare and Medicaid losses. Although there are many factors that affect hospital financial stability, BBA payment reductions, government reimbursement rates, and continued private payer pressures contribute significantly to the situation.

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## **RECOMMENDATIONS OF THE HOSPITAL STUDY FOCUS GROUP ON PAYMENT MECHANISMS**

In the summer of 2000, the Office of Health Care Access sponsored a focus group composed of hospital administrators, commercial payer executives, bond insurers, hospital auditors, and state officials to discuss hospital payment mechanisms and the financial status of Connecticut hospitals. The focus group offered the following observations:

### **Observations on the Current Financial Status of Hospitals**

- ♦ Hospital revenues are not keeping pace with costs. New technology, new safety rules for blood products, pharmaceutical advances, rising energy costs, and compliance with regulations, such as HIPAA, outpatient prospective payment method, and new, required testing of newborns, have driven hospital expenses upward.
- ♦ Hospital unit costs have increased by approximately 3%. Consequently, they have had to slash unit costs by 3% to maintain margins. This may not be sustainable and future cost reductions could result in reduced quality of care.
- ♦ Many Connecticut hospitals reported negative operating margins in 1999. The state is below the national average operating margin of 4% to 5%. Hospitals need a minimum of a 2% to 3% operating margin to refurbish their physical plants, keep current with technology, and have access to capital.
- ♦ Some hospitals are resorting to dipping into their endowments to cover cash losses. Others are deferring capital and other expenditures.

## **Recommendations on the Role of Government**

- ♦ Government reimbursements are insufficient to cover the cost of care and, therefore, must be improved. In Connecticut, Medicaid pays 71 cents on the dollar, the 3rd lowest payment-to-cost ratio in the nation.
- ♦ CHEFA, the Connecticut Health & Educational Facilities Authority, and OHCA should collaborate to evaluate what is needed for hospitals to maintain their financial solvency.
- ♦ The government must provide adequate funding for teaching and research—medical education is under-funded and needs additional dollars.
- ♦ The State should intervene regarding commercial payment issues—denials of payments and late payments have negatively affected hospitals' financial performance. The state should also help to simplify and standardize claims processing. OHCA should work with the Department of Insurance regarding these issues.
- ♦ The Outpatient Prospective Payment System mandated by HCFA is not operational—it requires a higher level of coding and more paperwork.

### **Observations on Interactions with the Insurance Industry**

- ♦ Insurance company pre-authorization requirements are labor intensive and costly.
- ♦ Private insurers are taking longer to pay claims. In some cases, claims processing is actually less automated than it formerly was because it often requires more human intervention to navigate a claim through the system.

## NOTES

- <sup>1</sup>*Brief Summaries of Medicare & Medicaid*. 2, <http://www.hcfa.gov/medicare/ormedmed.htm>.
- <sup>2</sup>The Lewin Group. (Feb. 23, 2000) *Independent Analysis of the Fairness and Equity of Connecticut Medicaid Hospital Reimbursement*.
- <sup>3</sup>IRS Title 26 Internal Revenue Code Sec. (501) (c) (3).
- <sup>4</sup>State of Connecticut Office of Health Care Access Hospital Budget Reporting System.
- <sup>5</sup>State of Connecticut Office of Health Care Access Hospital Budget Reporting System. The five large urban hospitals are Bridgeport, Hartford, Saint Francis, Saint Raphael's, and Yale-New Haven.
- <sup>6</sup>CT Office of Health Care Access Inpatient Database.
- <sup>7</sup>*Managed Care Discount Rates*, Office of Health Care Access, 2000.
- <sup>8</sup>[http://www.wa-ic.org/in\\_hist.htm](http://www.wa-ic.org/in_hist.htm), *Health Insurance, The History*, p. 1
- <sup>9</sup><http://www.bluecares.com/know/history.html>, *Get to Know Blue Cross and Blue Shield*, p. 1
- <sup>10</sup>[http://www.wa-ic.org/in\\_hist.htm](http://www.wa-ic.org/in_hist.htm), p. 2
- <sup>11</sup>Longest, Jr., Beaufort B., *Health Policymaking in the United States*, p. 20
- <sup>12</sup>Kuttner, Robert, *The American Health Care System: Employer Sponsored Health Care Coverage, New England Journal of Medicine*; (January 1999), p.248
- <sup>13</sup><http://www.insure.com/health/terms.html>, *Sorting out the details of private health insurance*, p. 2
- <sup>14</sup>CHIPS Consulting, *Handbook of Managed Care Terminology*, p. 33
- <sup>15</sup>[http://www.wa-ic.org/in\\_hist.htm](http://www.wa-ic.org/in_hist.htm), p. 4
- <sup>16</sup>[http://www.wa-ic.org/in\\_hist.htm](http://www.wa-ic.org/in_hist.htm), p. 4
- <sup>17</sup>State of Connecticut Office of Health Care Access, *Managed Care Discount Rates*
- <sup>18</sup>State of Connecticut Office of Health Care Access Hospital Budget Reporting System.
- <sup>19</sup>State of Connecticut Department of Insurance HMO Statistics for June 2000.
- <sup>20</sup><http://www.insure.com/health/terms.html>, p. 3
- <sup>21</sup>[http://www.allhealth.org/sourcebook/chp\\_05/ch05A\\_summary.html](http://www.allhealth.org/sourcebook/chp_05/ch05A_summary.html)
- <sup>22</sup>Grace and New Haven Hospital Annual Reports, 1868 – 1945 and Hospital Study Focus Group on Competition and Integration, 2000.
- <sup>23</sup>Iglehart, The American Health Care System: Medicare, *The New England Journal of Medicine*; (January 1999), 327 & Iglehart, The American Health Care System: Expenditures, *The New England Journal of Medicine*; (January 1999), 72.
- <sup>24</sup>State of Connecticut Office of Health Care Access Hospital Budget Reporting System.
- <sup>25</sup><http://www.hcfa.gov/medicare/ormedmed.htm>, p. 4
- <sup>26</sup>The State of Connecticut Office of Health Care Access Hospital Budget Reporting System and The Henry J. Kaiser Family Foundation, Medicare State Profiles, *State and Regional Data on Medicare and the Population it Serves*, September 1999, p. viii and the Office of Health Care Access Hospital Budget Reporting System.
- <sup>27</sup>All financial operations for Medicare are handled through two funds, one for Hospital Insurance and one for Supplementary Medical Insurance. The funds are special accounts in the U.S. Treasury that are credited with all income receipts and charged with all Medicare expenditures for benefits and administration costs. Medicare is funded from four different sources: mandatory contributions by employers and employees, general tax revenues, beneficiaries' premiums, and deductibles and copayments by patients. Social Security Bulletin, Annual Statistical Supplement, 1998, *Supplemental Security Income*, p. 81-108
- <sup>28</sup>Institute for the Future, *Health and Health Care 2010, the Forecast, the Challenge*, p. 52
- <sup>29</sup>Folland, Goodman, and Stanno, *The Economics of Health and Health Care*, 2<sup>nd</sup> Edition, p. 453
- <sup>30</sup>Longest, Jr., Beaufort B., p. 115
- <sup>31</sup><http://www.snm.org/policy/nprmsum.html>, Policy and Practice, Health Care Financing Administration Proposed Rule on the Hospital Outpatient Prospective Payment System, p. 1-2
- <sup>32</sup>State of Connecticut Office of Health Care Access Hospital Budget Reporting System.
- <sup>33</sup>Social Security Bulletin, Annual Statistical Supplement, p. 93

- <sup>34</sup>Iglehart, John K., *The New England Journal of Medicine*, January 28, 1999, Vol. 340, No. 4, The American Health Care System – Medicare, p. 1
- <sup>35</sup>Iglehart, John K., p. 3
- <sup>36</sup>Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 35
- <sup>37</sup><http://www.hcfa.gov/medicare/ormedmed.htm>, p. 12
- <sup>38</sup>State of Connecticut Office of Health Care Access Hospital Budget Reporting System.
- <sup>39</sup>The federal government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. Social Security Bulletin, p. 109-112
- <sup>40</sup>The Boren Amendment to the Medicaid law provided that state payment for hospitals and nursing facilities must be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities that meet state and federal standards.
- <sup>41</sup><http://www.hcfa.gov/medicare/ormedmed.htm>, p. 15
- <sup>42</sup>Iglehart, John K., *The New England Journal of Medicine*, February 4, 1999, Vol. 340, No. 5, The American Health Care System—Medicaid, p. 5
- <sup>43</sup><http://www.hcfa.gov/medicaid/mcsten99.htm>
- <sup>44</sup>State of Connecticut Office of Health Care Access Hospital Reporting System.
- <sup>45</sup>Congress and the Internal Revenue Service (IRS) regulate philanthropies. By law, they need disburse only five percent of their net assets annually for charitable purposes. In the United States today, there are more than 44,000 foundations. Approximately one-third, or 13,500, hold more than \$1 million in assets or make more than \$50,000 in yearly donations. In the latest year of record, foundations gave away nearly \$16 billion. Schroeder, Steven A., *Reflections on the Challenges of Philanthropy, Health Affairs*, (July/August 1998); p. 211 & <http://www.cof.org/whatis/types/contents.htm>, *Types of Foundations*.
- <sup>46</sup>With rising costs, the average statewide gain from operations fell from \$106 million in FY 1996 to \$13 million in FY 1998. State of Connecticut Office of Health Care Access Hospital Budget Reporting System.
- <sup>47</sup>The Lewin Group, *Independent Analysis of the Fairness and Equity of Connecticut Medicaid Hospital Reimbursement Executive Summary*, Feb. 23, 2000, p. 11.
- <sup>48</sup>The Lewin Group, *The Impact of the Medicare Balanced Budget Refinement Act on Medicare Payments to Hospitals*, American Hospital Association, Feb. 1, 2000, p. 23
- <sup>49</sup>The Lewin Group, *Independent Analysis of the Fairness and Equity of Connecticut Medicaid Hospital Reimbursement*, Feb. 23, 2000.